

STATE OF MARYLAND

Request for Proposals Prescription Drug Benefits

Solicitation No. F10R0200266

**Department of Budget and Management
Employee Benefits Division
February 22, 2000**

NOTICE

Prospective offerors who have received this document from a source other than the Issuing Office should immediately contact the Issuing Office and provide their name and mailing address so that the amendments to the RFP or other communications can be sent to them

Minority Businesses are Encouraged to Respond to this Solicitation

NOTICE TO OFFERORS

In order to help us improve the quality of State proposal solicitations, and to make our procurement process more responsive and Abusiness friendly≡, we ask that you take a few minutes and provide comments and suggestions regarding the enclosed solicitation. Please return your comments with your proposal. If you have chosen not to bid on this contract, please fax this completed form to: (**410 333-7122**).

Proposal Number: Solicitation No. F10R0200266

Entitled: Prescription Drug Program

Date: February 22, 2000

1. If you have responded with a Ano bid≡, please indicate the reason(s) below:
 - P Other commitments preclude our participation at this time.
 - P The subject of the solicitation is not something we ordinarily provide.
 - P We are inexperienced in the work required.
 - P Specifications are unclear, too restrictive, etc. (please explain in the Remarks section).
 - P The scope of work is beyond our present capacity.
 - P Doing business with State of Maryland Government is simply too complicated (please explain in the Remarks section).
 - P We cannot be competitive (please explain in the Remarks section).
 - P Time allotted for completion of the proposal is insufficient.
 - P Start-up/implementation time is insufficient.
 - P Proposal requirements (other than specifications) are unreasonable or too risky (please explain in the Remarks section).
 - P MBE requirements (please explain in the Remarks section).
 - P Prior State of Maryland contract experience was unprofitable or otherwise unsatisfactory (please explain in the Remarks section).
 - P Payment schedule is too slow.

Other:

2. If you have submitted a proposal, but wish to offer suggestions or express concerns, please use the Remarks section below (use reverse or attach additional pages as needed).

REMARKS:

Vendor Name: _____ Date: _____ Contact Person:

_____ Phone:

Address:

PROCUREMENT SCHEDULE

Prescription Drug Program

February 22, 2000	Advertisement of the Request for Proposals for Prescription Drug Services in Maryland Contract Weekly and Issuance of Request For Proposals
March 2, 2000	Requested date for receipt of written questions to be answered during the pre-proposal conference. Must be received at the Issuing Office by 10:00 a.m. local time.
March 7, 2000	Pre-proposal Conference at 10:00 a.m. 300 West Preston Street - 1st floor auditorium Baltimore, MD 21201
April 12, 2000	Closing date for submission of proposals. Proposals must received at the Issuing Office by 1:00 p.m.
May 15 - 19, 2000	Vendor Interviews (tentative)
July 19, 2000	Recommendation for Award at Board of Public Works Meeting

TABLE OF CONTENTS
SECTION 1. GENERAL INFORMATION

1.1	Summary Statement	1
1.2	Definitions	1
1.3	Issuing Office and Procurement Officer	3
1.4	Pre-Proposal Conference	4
1.5	Proposal (Closing) Due Date	4
1.6	Duration of Offer	4
1.7	Revisions to the RFP.....	5
1.8	Cancellation; Discussions	5
1.9	Oral Presentation.....	5
1.10	Incurred Expenses	5
1.11	Economy of Preparation	6
1.12	Disputes; Protests.....	6
1.13	Multiple and Alternative Proposals	6
1.14	Access to Public Records Act Notice	7
1.15	Offeror Responsibilities	7
1.16	Mandatory Contractual Terms	7
1.17	Proposal Affidavit.....	8
1.18	Contract Affidavit	8
1.19	Minority Business Enterprises	8
1.20	Arrearages	9
1.21	Procurement Method.....	9
1.22	Contract Duration	9
1.23	Contract Type.	10
1.24	Payment Terms.	10

SECTION 2. OFFEROR QUALIFICATIONS

SECTION 3. SPECIFICATIONS

3.1	Description of Current Plan	11
3.2	Desired Plan Design.....	17
3.3	Scope of Work	18
3.4	Deliverables/Delivery Schedule	24
3.5	Questionnaire	25

TABLE OF CONTENTS CONT=D

SECTION 4. EVALUATION CRITERIA AND SELECTION PROCEDURE

4.1	Evaluation Criteria.	51
4.2	Selection Procedure	52

SECTION 5. PROPOSAL FORMAT

5.1	General.	53
5.2	Format of the Proposal	53
5.2.1	Volume I - Technical Proposal	53
5.2.2	Volume II - Financial Proposal	55
5.2.3	Volume III - Pharmacy Participation Statements	55

ATTACHMENTS	56
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A:	Prescription Drug Benefit Service Agreement
B:	Proposal Affidavit
C:	Contract Affidavit
D:	Minority Business Enterprises Requirements
E:	Pharmacy Participation Statement
F:	Preferred Drug List
G:	Prescription Drug Plan
H:	Drugs Requiring Prior Authorization
I:	Managed Access Activity Statistics
J:	Performance Standards
K:	Financial Proposal
12:	Enrollment and Utilization Statistics
13:	Management Reporting Requirements
N:	Utilization Management Data Reporting Requirements

SECTION I. GENERAL INFORMATION

1.1 SUMMARY STATEMENT

The Department of Budget and Management is issuing a Request for Proposals (RFP) for pharmacy benefit management services, including comprehensive concurrent, prospective, and retrospective Drug Utilization Review, for Maryland State employees and retirees. The State will contract with one vendor for the desired services.

1.2 DEFINITIONS

For the purposes of this RFP, the following terms have the meanings indicated below:

AAACH≡ means Automatic Clearing House.

AAWP≡ means average wholesale price.

ABRC≡ means Benefits Review Committee. A committee comprised of state employees selected by the Secretary of DBM to review appeals of benefit plan decisions.

ACHAMP≡ means Comprehensive Health Analysis and Management Program.

ACOB≡ means coordination of benefits.

ACOBRA≡ means Consolidated Omnibus Budget Reconciliation Act.

ACOMAR≡ means Code of Maryland Regulations.

AContract Employee≡ means a non-permanent employee of the State of Maryland who is not eligible for State subsidy of benefits, but is eligible to enroll in the State of Maryland Benefits Program, paying full premium costs.

ACovered Lives≡ means each individual enrolled in a plan.

ADAW≡ means dispense as written.

ADBM≡ means the Department of Budget and Management.

ADEA≡ means Drug Enforcement Administration.

ADESI≡ refers to drugs identified by the Food and Drug Administration as lacking substantial evidence of effectiveness.

ADUR≡ means drug utilization review.

ADependent≡ means a spouse, natural child, step-child, legally adopted child, or legal ward of an eligible member, as defined in COMAR 06.01.07.03A(11).

ADirect Pay Enrollee≡ means an individual who is billed directly by the Department of Budget and Management for selected benefits.

AEBD≡ means Employee Benefits Division.

AEDI≡ means Electronic Data Interface

AEOB≡ means Explanation of Benefits.

AFTE≡ means Full-Time Equivalent.

AFTP≡ means File Transfer Protocol.

AHIPAA≡ means Health Insurance Portability Accountability Act.

AIVR/BAS≡ means Interactive Voice Response/Benefits Administrative System

ALeave of Absence≡ means a permanent employee who has elected a non-paid leave of absence from State of Maryland employment, who is not eligible for State subsidy of benefits, but is eligible to participate in certain benefits provided by the State of Maryland while on a leave of absence.

AMAC≡ means maximum allowable cost.

AMBE≡ means a Minority Business Enterprise that is certified by the Maryland Department of Transportation.

AMember≡ means an employee who is eligible to participate in the State of Maryland Benefits Program but does not include the member=s dependent(s).

AMIS≡ means Management Information System.

ANDC≡ means national drug code.

APart-Time Employee≡ means a permanent employee who works less than fifty percent of the standard work week and is not eligible for state subsidy of benefits, but is eligible to enroll in the State of Maryland Benefits Program.

AParticipating Pharmacy≡ means only those pharmacies for which the offeror has a signed participation statement as described in Attachment E.

APBM≡ means pharmacy benefit manager.

APDL≅ means preferred drug list.

APlan Sponsor≅ means the State of Maryland.

ARFP≅ means this Request for Proposals for pharmacy benefit management services.

ARPH≅ means registered pharmacist.

ASatellite Account Employee≅ means an employee of a political subdivision, agency, commission, or organization that is permitted by Maryland law to participate in the State of Maryland Benefits Program.

ATIN≅ means tax identification number.

ATPA≅ means Third Party Administrator.

ATTY/TDD≅ means a telephone device used by hearing impaired individuals whereby they communicate via telephone connected to a keyboard and screen.

AUR≅ means utilization review.

1.3 ISSUING OFFICE AND PROCUREMENT OFFICER

The sole point of contact in the State for purposes of this RFP is the Issuing Office at the address listed below:

State of Maryland
Department of Budget and Management
Employee Benefits Division
301 West Preston Street, Room 509
Baltimore, Maryland 21201
Attn: Gladys B. Gaskins
Telephone: (410) 767-4710
Fax: (410) 333-7122

The Procurement Officer is Joel Leberknight, 45 Calvert Street, Room 137, Annapolis, Maryland 21401, (410) 260-7116, Fax (410) 974-3274.

1.4 PRE-PROPOSAL CONFERENCE

A Pre-Proposal Conference will be held on Tuesday, March 7, 2000 at 10:00 a.m. in the auditorium located on the 1st floor, 300 West Preston Street, Baltimore, Maryland 21201. Attendance at the pre-proposal conference is not mandatory, but all interested offerors are encouraged to attend in order to facilitate better preparation of their proposals. The conference will be transcribed. A copy of the transcript of the pre-proposal conference will be made available to potential offerors at a nominal charge directly from the transcription company. In addition, minutes of the conference will be distributed, free of charge, to all vendors who are known to have received the RFP. Both written and verbal questions will be considered at the pre-proposal conference.

All questions, either verbal or written, should be submitted in a timely manner. In the case of questions not received in a timely manner, the Procurement Officer shall, based on the availability of time to research and communicate an answer, decide whether an answer can be given before the proposal due date. Answers to all substantive questions which have not previously been answered, and which are not clearly applicable only to the requestor, will be distributed to all vendors who are known to have received the RFP.

1.5 PROPOSAL (CLOSING) DUE DATE

Except as provided in COMAR 21.05.02.10, the proposals are to be received by the Issuing Office, no later than Wednesday, April 12, 2000 at 1:00 p.m., local time. Proposals may not be submitted by e-mail or facsimile.

1.6 DURATION OF OFFER

Proposals submitted in response to this RFP are irrevocable for 120 days following the closing date. This period may be extended at the Procurement Officer's request only by an offeror's written agreement.

1.7 REVISIONS TO THE RFP

If it becomes necessary to revise this RFP, amendments will be provided to all prospective offerors that were sent this RFP or otherwise are known by the Procurement Officer to have obtained this RFP. Acknowledgment of the receipt of all amendments to this RFP must accompany the offeror=s proposal. Failure to acknowledge receipt does not relieve the offeror from complying with all terms of any such amendment.

1.8 CANCELLATION; DISCUSSIONS

The State reserves the right to cancel this RFP, accept or reject any and all proposals, in whole or in part, received in response to this RFP, to waive or permit cure of minor irregularities, and to conduct discussions in any manner necessary to serve the best interests of the State of Maryland. The State also reserves the right, in its sole discretion, to award a contract based upon the written proposals received without prior discussions or negotiations.

1.9 ORAL PRESENTATION

Offerors may be required to make individual presentations to State representatives in order to clarify their proposals. Any statement made by an offeror during an oral presentation that significantly alters its proposal must be reduced to writing. Any such written submission becomes a part of the offeror=s proposal.

1.10 INCURRED EXPENSES

The State will not be responsible for any costs incurred by an offeror in preparing and submitting a proposal, in making an oral presentation, in providing a demonstration, or in performing any other activities relative to this solicitation.

1.11 ECONOMY OF PREPARATION

Proposals should be prepared simply and economically, providing a straightforward, concise description of the offeror's proposal to meet the requirements of this RFP.

1.12 DISPUTES; PROTESTS

Any protest or dispute related respectively to this solicitation or the resulting contract shall be subject to the provisions of COMAR 21.10 (Administrative and Civil Remedies).

1.13 MULTIPLE AND ALTERNATIVE PROPOSALS

An offeror may not submit multiple proposals for the required services under this RFP.

An offeror may submit an alternative proposal for the required services in addition to a proposal which fully conforms to the requirements of this RFP. This required fully conforming proposal shall be deemed to be the primary proposal. An alternative proposal, by definition, is a proposal which seeks to satisfy the overall objectives of this RFP, but which in some way takes exception to one or more specific requirements of this RFP. An alternative proposal may be selected for award if its proposed solution for providing the described services required under this RFP is judged superior to any proposal which does not take exception to any requirement of this RFP.

An alternative proposal must be clearly labeled as such and follow the same format as the primary proposal. However, an alternative proposal should contain only that information that differs in any way from the primary proposal. Each proposal must be bound separately and prepared in accordance with Section 5 of this RFP.

1.14 ACCESS TO PUBLIC RECORDS ACT NOTICE

An offeror should give specific attention to the clear identification of those portions of its proposal that it considers confidential, proprietary commercial information or trade secrets, and provide justification why such materials, upon request, should not be disclosed by the State under the Access to Public Records Act, Title 10, Subtitle 6, of the State Government Article of the Annotated Code of Maryland. This information is to be placed after the title page and before the table of contents in both the technical and financial proposals. Respondents are advised that, upon request for this information from a third party, the Department is required to make an independent determination whether the information may be disclosed (see COMAR 21.05.08.01).

1.15 OFFEROR RESPONSIBILITIES

The selected offeror shall be responsible for all products and services required by this RFP. Subcontractors, except those used exclusively to meet MBE participation goals, must be identified and a complete description of their role relative to the proposal must be included in the offeror=s proposal. Additional information regarding MBE subcontractors is required under paragraph 1.19 below.

1.16 MANDATORY CONTRACTUAL TERMS

By submitting an offer in response to this RFP, an offeror, if selected for award, shall be deemed to have accepted the terms of this RFP and the Contract, Attachment A. Any exceptions to this RFP or the Contract must be clearly identified in the Executive Summary of the technical proposal. A proposal that takes exception to these terms may be rejected.

1.17 PROPOSAL AFFIDAVIT

All proposals submitted by an offeror must be accompanied by a completed Proposal Affidavit. A copy of this Affidavit is included as Attachment B of this RFP.

1.18 CONTRACT AFFIDAVIT

All offerors are advised that if a contract is awarded as a result of this solicitation, the successful offeror will be required to complete a Contract Affidavit. A copy of this Affidavit is included for informational purposes as Attachment C of this RFP. This Affidavit must be provided upon notification of proposed contract award.

1.19 MINORITY BUSINESS ENTERPRISES

A Minority Business Enterprise (MBE) subcontract participation goal of 15 percent of the Total Administrative Fees found in the Financial Proposal, Attachment K, has been established for this procurement. The contractor shall structure its awards of subcontracts under the contract in a good faith effort to achieve the goal through businesses certified by the State of Maryland as minority owned and controlled. MBE requirements are specified in Attachment D of this RFP.

A current directory of MBEs is available through the Maryland State Department of Transportation, Office of Minority Business Enterprise, P. O. Box 8755, BWI Airport, Maryland 21240-0755. The phone number is (410) 865-1244, internet address, <http://www.mdot.state.md.us>, select AMBE≡.

1.20 ARREARAGES

By submitting a response to this solicitation, each offeror represents that it is not in arrears in the payment of any obligations due and owing the State of Maryland, including the payment of taxes and employee benefits, and that it shall not become so in arrears during the term of the contract if selected for contract award.

1.21 PROCUREMENT METHOD

This contract will be awarded in accordance with the competitive sealed proposals process under COMAR 21.05.03.

1.22 CONTRACT DURATION

The contract resulting from this RFP shall be for the period beginning on or about July 1, 2000 and ending on or about December 31, 2003. The offeror shall be responsible for providing pharmacy benefit management services for calendar years 2001, 2002 and 2003. The State, at its sole option, shall have the right to extend the contract term for three additional, successive one-year terms. For the period from contract commencement until December 31, 2000, the contractor shall be responsible for the activities described under Section 3.4. Beginning January 1, 2001, the contractor will also be responsible for processing claims incurred on or after January 1, 2001. Following the end of this contract (including any one-year extension(s) exercised by the State), the contractor shall be responsible for handling claims runout payments for claims incurred prior to the end of the contract for a period of 15 months following contract expiration, while the new vendor should be responsible for all new enrollees.

1.23 CONTRACT TYPE

The contract to be awarded shall be a fixed unit price contract for administrative expenses plus reimbursement of claims cost.

1.24 PAYMENT TERMS

If the State exercises its option to extend the contract, any administrative rate increase applicable to years 2004, 2005 and 2006 shall not exceed the amounts specified in this paragraph. The administrative rate increase shall be measured by the change in the Medical Care expenditure category of the Consumer Price Index for all Urban Consumers for the Baltimore-Washington published metropolitan area, unadjusted for seasonal variation (hereinafter ACPI-U Medical). The measurement period shall be the twelve-month period ended June 30, preceding the option period. The increase determined under this paragraph shall be applied to the administrative rates in effect for the prior year of the contract.

The contractor shall not receive compensation for services described under Section 3.4 performed prior to January 1, 2001 as part of the implementation of the new contract.

As described in Section 1.22, the contractor shall provide claims run out payments and related administrative services for up to 15 months following the end of the contract and shall be entitled to payment for such services as performed.

SECTION 2. OFFEROR QUALIFICATIONS

Offerors must demonstrate the following qualifications. Offerors must clearly state and demonstrate within the Executive Summary of their proposals that they satisfy each qualification and provide reference to the page number in their proposal where such evidence can be found. The qualifications are applicable to the primary offeror and any

subcontractors used by the offeror or primary functions under the Scope of Work. The offeror's proposal must demonstrate the offeror:

1. Has at least 5 years of experience in administration of retail pharmacy networks.
2. Provides point-of-sale services to a minimum of two million covered lives, including at least one client with 75,000 covered lives. The State account should not comprise more than 15% of the offeror's total current volume of prescriptions.

SECTION 3. SPECIFICATIONS

3.1 DESCRIPTION OF CURRENT PLAN

The State currently has a stand alone, self-funded prescription drug program which is administered by PCS Health Systems. It is the only prescription program offered by the State to its employees and retirees. None of the State's medical plans, including HMOs, offer prescription drug benefits. The Plan serves approximately 96,500 enrollees (188,000 total covered lives) living in Maryland and across the United States and in foreign countries. The total cost of the program, including administrative fees and claims, in 1999 was approximately \$126 million (exclusive of rebates).

The current pharmacy benefits manager (PBM) provides the State Plan with an extensive network of in-state, as well as out-of-state pharmacies, discounted drug pricing, point-of-sale claims adjudication, concurrent drug utilization review, a formulary for quality and cost control, manufacturer rebates, managed access services and authorization of early refills and advance supplies. Members use a prescription card to access services or submit direct claims when using a non-participating pharmacy. The plan features are described below.

3.1.1 Pharmacy Network

The State uses a nationwide point-of-sale pharmacy network, maintained by the PBM, with pharmacies in every state. There are 1,025 in-State pharmacies and 53,912 out-of-State pharmacies which participate in the network and offer discounted drug prices to the State Plan.

3.1.2 Drug Pricing

The State has an Average Wholesale Price (AWP) discount arrangement for single source drugs and Maximum Allowable Cost (MAC) pricing for selected multi-source drugs. The State Plan also includes a requirement for usual and customary pricing.

3.1.3 Member Co-pays

When using a network pharmacy, State Plan members are responsible for a \$3 co-pay for preferred drugs, \$5 co-pay for formulary drugs and a \$10 co-pay for non-formulary drugs. If a generic substitute is available and the Plan member chooses a brand drug, or if the prescribing physician has indicated Adispense as written≡ (DAW) for which a generic is available, the member is responsible for the difference in price between brand and generic, as well as the co-pay.

If Plan members use a pharmacy not in the network, they pay the entire cost of the prescription drug and submit a paper claim form to the PBM. In such cases, members are reimbursed for their payments minus a \$12.50 co-pay and the difference between the total charges and what the State would have paid a participating pharmacy.

During the term of the contract the State reserves the right to alter co-pays or switch to a percentage co-pay.

3.1.4 Covered Drugs

The State Plan provides coverage for insulin, rabies vaccine, and most legend drugs prescribed on an outpatient basis, including:

- < Allergy serum;
- < Compounded medication of which at least one ingredient is a legend drug;
- < Growth hormones;
- < Lupron;
- < Oral contraceptives, Norplant, Depo-provera;
- < Dexedrine;
- < Adderall;
- < Viagra;
- < Ritalin; and
- < Tretinoin, all dosage forms (e.g., Retin-A) for individuals through the age of 25.

3.1.5 The State Plan currently does not cover:

- < Anorectics (any drug used for the purpose of weight loss);
- < Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- < Charges for the administration or injection of any drug;
- < Contraceptive devices; except as mentioned above;
- < DESI drugs (drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness);
- < Dietary supplements;
- < Drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
- < Immunization agents, biological sera, blood or blood plasma;

- < Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- < Minoxidil (Rogaine), Propicia and Renova;
- < Non-legend drugs other than insulin and rabies vaccines;
- < Prescriptions which an eligible person is entitled to receive without charge under Workers' Compensation Law;
- < Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use; or
- < Vitamins, singly or in combination, including prescription prenatal and fluoride.

3.1.6 Dispensing Limitations

Most prescriptions are dispensed in the amount normally prescribed by the physician, but not to exceed a 90 day supply. Exceptions include legend oral contraceptives, which may be dispensed in up to a 6 month supply, and the following drugs, which may be dispensed in up to a 100 day supply:

Albuterol Inhalation	Corticosteroids Inhalants	Isoniazid
Amylase/Lipase/Protease	Dipyridamole	Ketoprofenl (Oruvail)
Anticonvulsants	Diuretics	Magestrol
Antihyperlipidemic Agents	Dorzolamide (Trusopt)	Nabumetone (Relafen)
Antihypertensives	Etodolac (Lodine)	Oral Hypoglycemics
Antiparkinson Drugs	Finasteride (Proscar)	Oxybutynin
Antithyroid Drugs	Glaucoma Agents (Oral)	Parasympathomietics
Azathioprine	Gout Agents	Potassium Supplements
Balclofen	Hormones	Taxoxifen Citrate

Bronchodilators (Oral)	Hydroxychloroquine	Thyroid Hormones
Cardiovascular Agents	Insulin	Wafarin

3.1.7 Managed Access

Managed Access allows for the dispensing of drugs outside of the contract=s normal limitations and exclusions. Managed Access includes but is not limited to early refills, advance supplies, and selected drugs that require pre-authorization by the PBM. In addition, any drugs authorized by the BRC included in Managed Access. The selected PBM must handle early refills, advance supplies, and pre-authorization requirements according to mutually agreed upon protocol. Selected drugs require written documentation from the participant=s doctor stating the diagnosis and reason for the medication. A list of these Managed Access drugs and the approved diagnoses is included as Attachment H. The State allows refill of both acute and maintenance drugs at 75%. Exceptions are made for Plan members requiring early refills and advance supplies who provide documentation from their doctor as to why an early refill/advance supply is necessary (i.e., change in dosage level, leaving the country, etc.). Attachment I includes activity statistics for early refills/advance supplies and for Managed Access drugs.

The selected PBM will be asked to advise the State of any changes to the Managed Access list and protocols that the PBM believes appropriate.

3.1.8 Formulary Incentive

The PBM maintains a formulary of preferred drugs which provides quality cost-effective treatment for members of the State Plan. This list, subject to the approval of the State, is developed by the PBM=s panel of physicians and pharmacists who meet regularly to review and identify prescription drugs which provide the highest therapeutic and economic value. As noted earlier, formulary drugs have a \$5 co-pay while non-formulary drugs require a \$10 co-pay.

A portion of the formulary is identified as Preferred Performance Drugs. These performance drugs listed in the PDL have a \$3 co-pay and are provided in Attachment F.

3.1.9 Generic Drug Incentive

With limited exceptions, the Plan pays only the cost of generic drugs, if a generic is available. There are a few brand drugs for which generics are available, which are reimbursed at the brand price for reasons of limited generic availability or based on the clinical judgement of the PBM (e.g., Dilantin, Synthroid). Generally, however, when members choose a brand drug when a generic is available, or even if a member's doctor requires the use of a brand-name drug when a generic is available (DAW), the member must pay the difference in cost between the brand and generic.

3.1.10 Manufacturer Rebates

The State currently receives manufacturer rebates negotiated by the PBM.

3.1.11 Drug Utilization Review

As part of the point of sale system, the PBM provides concurrent DUR services. The PBM also provides retrospective and prospective DUR services.

3.1.12 Plan Eligibility

The Plan covers all State employees and retirees who are eligible under COMAR 06.01.07 to enroll in a health plan and COBRA participants. Briefly, dependent coverage is available for spouses and eligible dependent children. Dependent children are eligible for coverage until the end of the calendar year in which they turn 19. If they are full-time students, they are eligible until the end of the calendar year in which they turn 25 or until the end of the month in which they cease to be full-time students, whichever occurs first. There is no age limit for the eligibility of a disabled dependent child as long as the disability began prior to

the 19th birthday (25th if a full-time student).

3.1.13 Plan Participation and Utilization

Enrollment and utilization statistics for 1997, 1998 and 1999 are provided in Attachment L.

3.1.14 Plan Premiums

The State subsidizes 80% of the prescription plan total premium for actives and retirees. Plan premiums include cost for utilization review but may not reflect the total cost of the program.

<u>PLAN</u>	<u>YEAR 2000 MONTHLY MEMBER CONTRIBUTION</u>	<u>YEAR 2000 MONTHLY STATE SUBSIDY</u>	<u>YEAR 2000 TOTAL MONTHLY PREMIUM COST</u>
Member Only	\$15.96	\$63.82	\$79.78
Member & One Child	\$21.20	\$84.82	\$106.02
Member & Spouse	\$26.48	\$105.92	\$132.40
Member +2 or More	\$31.91	\$127.64	\$159.55

Satellites, COBRA and Direct Pays must submit total premium.

3.2 DESIRED PLAN DESIGN

The State wishes to continue the current plan design as described in Section 3.1. All co-pays, benefit limitations and exclusions will remain in effect with the exception of prescription pre-natal vitamins which will become an eligible expense starting January 1, 2001.

The State requires the formulary to closely match the current State=s formulary including the performance drug list (PDL). The current State=s formulary is available on the Internet at <http://www.Druglist.com>. The PDL is summarized in Attachment F.

3.3 SCOPE OF WORK

The State is seeking a pharmacy benefits manager (PBM) to provide a well managed, high quality, cost-effective prescription drug program and ensure responsible customer service for State Plan members.

The PBM must provide the following:

- A. A pharmacy network adequate to meet the needs of both in-state and out-of-state plan members.
- B. Discounted prescription drug pricing, including MAC (maximum allowable cost) pricing for multi-source drugs, and retail pharmacy agreements that accept the discounted price (plus co-pay) as payment in full.
- C. Administration of a participant co-payment structure that is multi-tiered and can assess price differentials as described in Section 3.1
- D. A formulary that assures therapeutic and economic value for Plan members and the State and covers all therapeutic diagnostic categories.
- E. Managed Access services as described in Section 3.1.
- F. Drug utilization review that will effectively and efficiently identify and address instances of potential fraud and abuse, as well as key prescribing and utilization patterns.
- G. The maximum rebates from any source.
- H. Routine management reports that will enable the State to effectively manage the prescription program and monitor and project program expenditures. A description of the management

reports is included in Attachment M.

1. The contractor shall report utilization management data to the State=s utilization management database system contractor on a calendar quarterly basis (quarters ending March 31, June 30, September 30 and December 31). The contractor=s quarterly reports shall include the data elements listed and be provided in the format specified in Attachment N. All data must be reported in an Aunscrambled≡ format, with actual Social Security numbers attached to each record. Reports must be submitted no later than the 10th business day of the month following the end of the calendar quarter.
- J. Enrollment services include:
 - i. issue and distribute ID cards and informational packets, to be in members' hands no later than the date on which the program becomes operational and throughout the year for new enrollees, as well as replacement cards for those that are stolen or lost;
 - ii. develop descriptive plan information for the Open Enrollment booklet;
 - iii. attend Open Enrollment Health Benefit Fairs each year of the contract, including option years, to answer questions and provide plan overview information;
 - iv. accept the State=s format of eligibility information using the State=s file transfer protocol (FTP) (All eligibility must be posted within two working days); and
 - v. develop and provide paper claim reimbursement forms for Plan members.
- K. A toll free 24-hour, 7 days a week telephone number fully exclusive to State Plan members to facilitate State participants= access to services.
- L. The call center should be staff from 8:00 a.m. to 5:00 p.m., Monday through Friday,

local time, except on State observed holidays.

- M. An Account Service Manager who will serve as a liaison between the contractor and the State. This individual will work full time on-site at the State=s 301 W. Preston Street building for the duration of the contract.

The Account Service Manager must demonstrate previous experience in assisting with problems, issues or concerns experienced by enrollees and process Manage Access requests.

The State will provide on-site office space, including basic office furniture, and local telephone service connection for the Account Service Manager=s use when working on-site.

- N. Direct on-line access to the PBM=s system for purposes of special non-routine enrollments, terminations, and enrollment changes (e.g., addition of a dependent), and member enrollment verification by terminal connection via modem. The contractor must provide and install two computers for use at the Employee Benefits Division compatible with current equipment. One computer is used for enrollment data transmission and the other computer is for use by the on-site Account Service Manager. All associated costs and training of State employees are to be paid by the contractor.
- O. Accomplishment of performance standards as described in Attachment J or as subsequently agreed to by the vendor and the State.
- P. The contractor shall comply with all standards required under state and federal laws and regulations (e.g., HIPAA, EDI and privacy standards, etc.) and shall meet any state mandated benefit provisions that may be required during the term of the contract.
- Q. The PBM will be responsible for payment of claims, dispensing fees, etc. to all providers through a bank account maintained by the PBM. All account

reconciliations, check stock, maintenance of the account will be handled by the PBM. The State will reimburse the PBM for claims on a bi-weekly basis and will pay administrative fees on a monthly basis as follows:

- R. Share the expense for printing the State of Maryland Open Enrollment booklet and universal enrollment forms, cost for which will be shared equally among all benefit plans, including medical, dental, prescription drug, mental health and substance abuse, life insurance, personal accident and dismemberment and long-term care insurance.

Claims Reimbursement:

Prior to the beginning of the calendar year, the PBM will provide the State with an annual APayment Schedule≡ to include:

- a) Cycle period - Identifying Number of Invoice, ie. Calendar year followed by bi-weekly period, 2001 - 01 represents the first bi-weekly period in Calendar year 2001.
- b) Invoice Date - Date invoice was prepared.
- c) Notification Date - Date the State will be notified of invoice. Invoice may be faxed to the Fiscal Services Unit of EBD.
- d) Due Date - Date funds are due in the PBM=s account.

On a biweekly basis, the PBM will ensure that a proper invoice signed by authorized personnel be provided to the State by a means (e.g., fax or express mail) which will allow the State to receive the invoice by the ANotification Date≡ noted on the APayment Schedule≡. The invoice should include the following:

- a) Period covered - Bi-weekly claim period covered by the invoice, e.g., 01/01/2001 through 01/14/2001.
- b) Invoice date - Date invoice was prepared.
- c) Invoice amount - Dollar amount of claims to be reimbursed detailed as follows:
 - 1) Participants Groups separated by active, retiree, satellite and direct bill - COBRA.
 - 2) Type of Claim - Pharmacy, Direct, Adjusted, etc.

- 3) Card Holder Claims - Number and Amount
- 4) Dependent Claims - Number and Amount
- 5) Total Claims - Card Holder plus Dependent Claims
- 6) Claims to be separated by year incurred, e.g., run-out claims/current year claims
- 7) Summary report, to include totals of all categories.

On a biweekly basis, the PBM will provide claims data to support the bi-weekly invoice submitted to the State. The PBM agrees to provide this data in a format to be determined by the State.

The State will provide an initial estimated claims reimbursement to the PBM based on claims for the last billing cycle covered by the current contract. This amount will be provided to the PBM by the first A Due Date as noted on the PBM's A Payment Schedule. The State will not provide an advance but will provide an estimated payment of claims which the PBM will have paid to providers. After the initial estimated payment,

bi-weekly claims payments will be based on a reconciliation process. The second payment will be calculated on two figures:

- 1) a payment for the Cycle period 2 will be based on the actual claims from the Cycle period 1 and
- 2) an adjustment for the Cycle period 1 by determining the difference between the initial estimated payment for the Cycle period 1 versus the actual claims paid by the PBM for the Cycle period 1. This difference will be added or subtracted to the payment for Cycle period 2.

Example of the calculation

VENDOR #	RX PAYMENT CALCULATION		
EXAMPLE ONLY	CYCLE PERIOD #2001-02		Due Date: 01/28/01
Payment for Cycle Period 01 01/01/01-01/14/01			Payment for Cycle Period 02 01/15/01-01/28/01 A
Based on claims 12/18/00-12/31/00			Based on claims 01/01/01-01/14/01
1000-ACTIVES	2,956,133.04		2,832,897.24
2000-SATELLITES	68,547.42		60,333.95
3000-COBRA	90,476.49		83,642.01
4000-RETIRES	<u>2,423,277.91</u>		<u>2,266,573.45</u>
Total Payment	5,538,434.86		5,243,446.65
Actual Claims Cycle Period 01			
1000 - ACTIVES	2,832,897.24		
2000 - SATELLITES	60,333.95		
3000 - COBRA	83,642.01		
4000 - RETIRES	<u>2,266,573.45</u>		
Total claims 01/01/01-01/14/01	5,243,446.65		
Adjustment for Cycle Period 01 01/01/01-01/14/01			
1000-ACTIVES	(123,235.80)		(123,235.80)
2000-SATELLITES	(8,213.47)		(8,213.47)
3000-COBRA	(6,834.48)		(6,834.48)
4000-RETIRES	<u>(156,704.46)</u>		<u>(156,704.46)</u>
Total Adjustment B	(294,988.21)		(294,988.21)
Payment for Cycle Period 02 01/15/01-01/28/01			
1000-ACTIVES			2,709,661.44
2000-SATELLITES			52,120.48
3000-COBRA			76,807.53
4000-RETIRES			<u>2,109,868.99</u>
Total Payment Cycle Period 02	A + B		4,948,458.44

Administrative Fees:

On a monthly basis, the PBM will submit a proper invoice for administrative fees signed by authorized personnel to the State. The invoice should include the following:

- a) Period covered - Month covered by the invoice, i.e., 01/01/2001 through 01/31/2001.

- b) Invoice date - Date invoice was prepared.
- c) Invoice amount - Dollar amount of administrative fees to be reimbursed detailed as follows:
 - 1) Carrier Groups separated by active, retiree, satellite and direct bill - COBRA.
 - 2) Type of Claim - Pharmacy, Direct, Adjusted, Miscellaneous etc. Should include paid, denied or adjusted
 - 3) Card Holder Claims - Number and Amount
 - 4) Dependent Claims - Number and Amount
 - 5) Total Claims - Card Holder plus Dependent Claims
 - 6) Summary report, to include totals of all categories

R. An annual State approved member satisfaction survey specific to the State account.

3.4 DELIVERABLES/DELIVERY SCHEDULE

The contractor must meet the following implementation schedule:

DATE	ACTIVITY
Upon contract commencement	Begin implementation meetings with the State of Maryland
Within 7 calendar days of contract commencement	Start development of information transfer and vendor activities/transition protocol with current vendor
30 calendar days after contract commencement	Complete development of information transfer and vendor activities/transition protocol
September, 2000	Attend Benefit Coordinators Training Sessions
October, 2000	Attend Open Enrollment and Benefit Fairs
January 1, 2001	Commence Benefit Coverage

3.5 QUESTIONNAIRE

The following questions are designed to solicit information critical to the State's evaluation of the offeror's capabilities in terms of the evaluation criteria identified in Section 4.1 of this RFP. Although the offeror's standard material may contain the requested information, the responses in this section will be an important/critical component in the evaluation. In responding, offerors should repeat each question, followed by the answer. Answers should be concise, but complete. Offerors must respond specifically to each question in this section, regardless of whether the information appears in or may be gleaned from other sections of the offeror's proposal. Failure to respond in this section to all applicable questions may result in rejection of the offeror's proposal. To assist offerors in the preparation of their responses, a copy of this questionnaire is available as part of the RFP in WordPerfect 6.1 or Microsoft Word 97 format in either a disk format or by contacting the Department's Internet web site at <http://www.dbm.state.md.us>, select Aprocurement.

ORGANIZATION

Organization Name:

Primary Contact:

Title:

Headquarters Address:

Telephone Number:()

Fax Number:()

E-Mail Address:()

1. Provide a brief summary of the history of your company and information about the growth of your organization on a national level and within the State of Maryland. Provide the following information about your company:
 - a. Organization's legal name
 - b. State of incorporation or headquarters

- c. Date of incorporation or founding
- 2. Describe any significant litigation and/or government action taken, proposed or pending against your company or any entities of your company during the most recent five (5) years.
- 3. Provide the addresses, including city and state, for the following activities proposed to be used for the State account. If more than one of any of the following will work on the State of Maryland contract, provide the requested information for all such offices.
 - a. Corporate/Firm Management Office
 - b. Customer Service Office
 - c. Provider Service Office
 - d. Account Management/Client Services Office
 - e. Technical Support Office
- 4. Provide the names, location, telephone numbers and brief resumes for each of the following proposed contacts for the State of Maryland:
 - a. The person representing your company during the proposal process
 - b. Primary account service representative
 - c. Account manager
 - d. Chief pharmacist
 - e. Customer service manager
 - f. Claims manager
- 5.
 - a. Explain your organization's ownership structure, listing all separate legal entities. Describe all major shareholders/owners (10% or greater ownership) and list the percent of total ownership of each such shareholder.
 - b. Describe how long the current ownership structure has been in place.
 - c. Note any changes in ownership structure that have occurred within the last two years.
 - d. Note any changes in ownership structure anticipated to occur within the next two years.

- e. List any ownership interest your company has in any business that provides a service or product related to medical care, including any contractual relationship or ownership by drug manufacturing companies or drug wholesalers. Describe the relationship.
6. Provide a profile of your retail pharmacy benefit management business for each of the last three calendar years (1999, 1998, and 1997).

	1997	1998	1999
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Total client base

Dollar amount of claims paid

Number of clients

Number of employees/retirees covered

Number of prescriptions filled

Public sector clients

Dollar amount of claims paid

Number of clients

Number of employees/retirees covered

Number of prescriptions filled

Clients that terminated during the year

Dollar amount of claims paid

Number of clients

Number of employees/retirees covered

Number of prescriptions filled

7. Provide copies of one or more of the most recent reports on your company's claims paying ability from the rating services of one or more of Standard & Poor, Moody's, Duff and Phelps and Best's. (If you are not rated by one or more of these organizations, please explain). Has there been any change in your ratings in the last two (2) years? If yes, explain the nature and reason(s) for the change.

8. Provide copies of your company's Annual Reports, audited financial statements. or if not publicly traded, the best available financial statements for your most recent three fiscal years.
9.
 - a. Identify what general liability and errors and omissions you carry to protect your clients. Describe the type and limits of each coverage that would protect this plan. What, if any, changes do you intend to make to these coverages if you are the successful contractor?
 - b. Describe your company=s minimum insurance requirements for affiliated pharmacies.
10. List your three (3) largest current retail pharmacy clients in terms of membership located outside of Maryland. For each client provide:

Client name & address

Name, title & telephone number of
person we may contact

Number of employees/retirees
covered

Total number of employees/retirees
of the client

Length of time they have been a
client

11. List your three (3) largest current retail pharmacy clients in terms of membership located in Maryland. For each Maryland client provide:

Client name & address

Name, title & telephone number of
person we may contact

Number of employees/retirees
covered

Total number of employees/retirees
of the client

Length of time they have been a

Client name & address
client

12. List three (3) former retail pharmacy clients that have terminated their contracts with your organization within the last 24 months. For each terminated client provide:

Client name & address

Name, title & telephone number of
person we may contact

Number of employees/retirees
covered

Total number of employees/retirees
of the client

Length of time they have been a
client

Reason for terminating contract

Subcontractor Information - NOTE: Although the following three questions are preferred to be submitted with your proposal, the offeror is not required to identify MBE subcontractors until 10 working days after notification of intended contract award.

13. Do you now subcontract with any other organization(s) for professional services? If so, provide a description of your subcontracting arrangements.
14. Provide the same information requested in Questions 1 through 7, 12, 13 and 14 for each subcontractor that you propose to have perform any of the required functions under this contract. Clearly identify if a proposed subcontractor is a minority business enterprise certified by the State.

PROGRAM ADMINISTRATION

15. Describe your current formulary program.
- a. Discuss your philosophy and objectives for the program.
 - b. How many drugs are included on your most recent formulary?

- c. Of the drugs on your formulary, how many generate rebates?
 - d. How many therapeutic categories are covered?
 - e. Identify those therapeutic categories not covered.
 - f. Describe the process and frequency for reviewing drugs for addition/deletion to the formulary.
 - g. Who makes the decisions on which drugs are included in the formulary? Describe their technical expertise.
 - h. Describe the factors considered and their relative importance in deciding whether a drug should be on the formulary.
 - i. How many drugs were added/deleted to your formulary in 1999?
 - j. How do you communicate your formulary list and formulary updates to prescribers, pharmacists, and members?
 - k. Describe how you would structure and implement a formulary for the State. Include a proposed formulary list as an Microsoft Excel spreadsheet.
 - l. How will the proposed formulary compare to the State=s current formulary as of January 1, 2000? Provide a list of all deviations.
16. a. List the manufacturers on your formulary and the percentage each comprises of the total.
- b. If you are owned by a pharmaceutical manufacturer:
- i. Describe your policy relative to that manufacturer=s drug products.
 - ii Identify those drugs on your formulary that are products of your parent company.
 - ii Explain how the State can be assured that the formulary will work to the State=s and its members= benefit where these drugs are concerned.
17. a. Can you administer the separate copays for formulary, brand and generic drugs?
- b. The State=s plan requires participants to pay the brand-name co-pay for DAW prescriptions when a generic is available. How will you ensure that the brand name co-pay is charged?

- c. The State=s plan requires participants to pay the difference between a brand-name and generic drug. How will you ensure that the amount to be paid will always be based on the lesser of AWP discounted or retail charges.
18. Provide a list of the deviations, if any, from the current plan design. This should include coverage exclusions and limitations for your network and non-network options.
19. Describe the coverage portability for members who temporarily reside or transfer to non-network service areas.
20. a. Describe the procedure for identifying and processing requests for early refills and advance supplies. Discuss the flexibility for Plan specific early refill limits. Can you assure immediate authorization of early or advance refills, or access to managed drugs in emergency cases when requested?
- b. Describe your ability to limit access at point-of-sale for selected drugs identified by the State as requiring pre-authorization. Describe the procedure for processing requests for pre-authorization drugs, including denials.
21. a. What sources and processes do you utilize to determine AWP pricing?
- b. How frequently is your system updated?
22. a. Describe your MAC program in detail, including MAC options, number of drugs covered, MAC price sources and cost calculations, revisions to the list and pharmacy acceptance.
- b. How do you determine the cost for generic drugs not included in your MAC program?
- c. Explain how MAC are determined geographically (by the location of the client, pharmacy, or other). Include a description of how specific areas are delineated (five digit zip, three digit zip, by county).
23. a. List the manufacturers with whom you currently have rebate agreements.
- b. What percentage of your total business is with each of these manufacturers?

- c. What percentage of your total rebate business is with each of these manufacturers?
- d. Describe the methodology for sharing rebates with the State.

24. Based on your overall business please complete the following table excluding over-the-counter products.

NDC Classification	Drug Class Description	% of All Rx	Within Class of Generic	Average Single Source Brand Ingredient Cost	Average Multi Source Brand Ingredient Cost	Average Generic Ingredient Cost
100	199 Anesthetics					
200	299 Antidotes Antimicrobials, Pennicillins					
300	399 Antifungals, etc.					
400	499 Blood Related					
500	599 Cardiovascular Central Nervous System Antidepressants					
600	699 Antipsychotics, etc.					
700	799 Radiopharmaceuticals					
800	899 Gastrointestinals					
900	999 Metabolics/Nutrients Hormones/Hormonal Mechanisms,Infertility					
1000	1099 Growth, etc.					
1100	1199 Immunologics					
1200	1299 Skin/Mucous Membranes					
1300	1399 Neurologics					
1400	1499 Oncolytics					
1500	1599 Ophthalmics					
1600	1699 Otics					
1700	1799 Relief of Pain					
1800	1899 Antiparasitics					
1900	1999 Respiratory Tract					
2000	2099 Unclassified/Miscellaneous					

NDC Classification	Drug Class Description	% of All Rx	Within Class of Generic	Average Single Source Brand Ingredient Cost	Average Multi Source Brand Ingredient Cost	Average Generic Ingredient Cost
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2100 Homeopathic Products

CUSTOMER SERVICE

25.
 - a. Describe your customer service department(s). Include the hours of operation, staffing, experience level and training.
 - b. Describe how customer services staff is notified of a client=s plan provisions and changes to the plan.
 - c. Is a registered pharmacist available for clinically-related inquiries?
26.
 - a. How will you ensure an incoming call to the State=s exclusive customer service access line will be identified as a State member to the customer service representative?
 - b. Will customer service representatives and supervisors be exclusively assigned to this account? Provide a staffing plan with the number of employees to be assigned to the State account, and an organization chart.
27.
 - a. Are customer service representatives separate from the claim processing unit, or do claim processors have customer service responsibilities? Describe how member services and claim processing systems are integrated.
 - b. Do customer service representatives have on-line access to up-to-date claim processing information?
 - c. Do customer service representatives have authority to approve claims?
 - d. What access do customer service representatives have to a registered pharmacist?
28. What hours will the State=s toll-free telephone access be staffed in addition to hours specified in Section 3.3? For the designated service office, how will you handle routine and emergency calls, both during regular office hours and during non-office hours?

29. Provide the percentage of telephone calls handled directly by RPHs, other clinically trained personnel, and non-clinically trained personnel?
30. Identify your average actual telephone response statistics for each office that will provide services for this contract during normal business hours for the 1999 calendar year based on the following categories:

Time until initial answer

Time until abandonment

Time from initial answer until connected to
a customer service representative

Average talk time

Number of calls received per day

Number of calls abandoned per day

Number of external calls out

31. a. List the types of inquiries that can be handled by customer service representatives.
- b Provide a brief description of the information available to customer service representatives.
- c. Do customer service representatives view the same on-line system as retail pharmacies?
- d. What is your response time to a request for the issuance of new cards, either to a new member or current member?
- e. Give examples of questions that will be referred to the State Employee Benefits Division.
32. Provide a sample communications package, including information on:

- a. Location of pharmacies
 - b. How to use network services
 - c. How to access member services
 - d. How to file non-network claims (claim forms)
 - e. Enrollment forms and ID cards
 - f. Explanation of Benefit (EOB) forms
 - g. Description of how to access the formulary list
33. Provide a draft plan description to be included in the Open Enrollment booklet. The plan description must describe in detail the procedures to be used by eligible members to obtain retail pharmacy services. To assist offerors in the preparation of this draft, a copy of the plan description included in the Prescription Drug Plan Section of the Summary of Benefits booklet for the plan year beginning January 1, 2000 is included as Attachment G.
34. Do you provide member support services for selecting and/or locating network pharmacists? Do your member support services personnel have on-line access to network pharmacy listings and locations to assist members with pharmacy selection? What other member services are provided with regard to pharmacy selection assistance? What notification and assistance do you provide plan members if a network pharmacy terminates their contract during the plan year?
35. a. How often are pharmacy directories updated and distributed to plan members?
- b. Is the pharmacy directory available on the Internet? How often is the directory updated on the Internet? Please provide the web site address. Is it possible to include a link on your web site back to the State=s Employee Benefits Division web site? What other services are available using the Internet?
36. Describe how the State or a plan participant can nominate pharmacies to be

considered for inclusion in the network.

37. In order to educate members of the cost of drugs, state your ability to include on the member=s pharmacy receipt the dollar amount that the State is paying toward the cost of that prescription.

CLAIM PAYING SERVICES AND ABILITY

39. Provide the following information for the retail pharmacy claim office facility(ies) that would service the State.

Years in operation _____

Number of prescriptions processed during Calendar Year 1999 _____

Average Number of prescriptions per processor per day _____

Number of plans presently administering _____

Financial accuracy as a percent of total claims dollars
paid (include over/underpayments)

Coding accuracy as a percent of total claims submitted

Staffing	Number	Average Years Experience	Annual Turnover Rate (%)
Processors			
Supervisor			
Managers			
Pharmacists			

What are normal hours of operation including extended or weekend shifts?

39. a. Describe your claims paying capacity and your ability to take on this account. Do you anticipate hiring additional personnel if you are awarded the contract?

- b. Describe the training received by claims processors, supervisors and other management staff.
- 40. For the claim office proposed, what is the number of working days for a paper claim to be processed (check issued) from the date of receipt, without coordination of benefits? On what basis do you make that representation (e.g., average turnaround time over the past 12 months)?

What percent of claims are processed within 10 working days from date of receipt: _____

What percent of claims are processed within 30 working days from date of receipt: _____

41.
 - a. What percentage of your network pharmacies have a point-of-sale capability?
 - b. Are on-line transactions posted using real-time processing?
 - c. What member information is maintained on-line for the pharmacists?
 - d. How long is member information kept on the system?
42. Describe your data exchange process for claims submission at the point-of-sale, including turnaround time. Provide a process flow illustration.
43. Does your company provide on-line, 24-hour, 7-day per week point-of-sale system availability? Provide statistics on reliability.
44. How many times during the last six months of 1999 were your systems unavailable to network pharmacies for more than ten minutes?
45. Describe your procedures for monitoring and analyzing your system=s performance.
46. Describe the back-up procedures a point-of-sale pharmacist would follow to verify eligibility, collect the proper co-pay, and process the claim should the pharmacist not be able to access the point-of-sale system.
47.
 - a. What criteria do you utilize to determine pharmacy, physician and member eligibility?
 - b. Confirm your ability to meet the State requirements of obtaining a valid and accurate DEA number for each prescription prior to processing.
48.
 - a. What procedures does a pharmacist follow when the system returns ineligible status but the member claims he or she is eligible?

b.c. What procedures are followed when the member notices a discrepancy in the retail charge?

49. a. List all edits routinely performed by your claims processing system, including DUR edits.
- b. Provide a complete list of electronic messages that can be transmitted to the pharmacist at the time of dispensing.
- c. Describe what action is taken to resolve mismatches or transactions that do not pass the edit process.
- d. Complete the following table separately for your retail pharmacy network program.

DUR Edit Criteria	Standard Edit Criterion (check if yes)	Percent of Pharmacies that Satisfy Criterion	Percent of Pharmacies that have On- line Access to Edits	Percent of Total Prescriptions Denied in 1999
Eligible Employee/Dep.				
Eligible Drug				
Contract Price of Drug				
Drug Interactions				
Duplicate Prescription				
Refill too Soon				
Proper Dosage				
Proper Days Supply				
Generic Availability				
Patient Copayments				
Other (List)				

50. a. What procedures does a pharmacist follow when the system returns a clinical on-line alert?
- b. What documentation, if any, is required?
- c. How is compliance monitored?

51. Provide the percentage of pharmacies in the State of Maryland that do not have point-of-sale capabilities. If pharmacies do not have point-of-sale capabilities, describe how claims are processed. Submit a flow chart, including time frames.
52. If a purchase is made at a non-network pharmacy, describe how claims are submitted and processed.
53. Describe any financial incentives to network pharmacies that are tied to utilization rates, compliance goals, quality of care outcomes or other performance results.
54.
 - a. Indicate the data elements on reimbursements to specific pharmacies that are captured and tracked.
 - b. What action is taken against pharmacies for abusive or excessive billing practices?
55.
 - a. How do you reimburse the pharmacists for multiple prescriptions for the same patient?
 - b. Do pharmacists receive full dispensing fees for each prescription?
 - c. Is a sliding scale on dispensing fees used for the first and subsequent prescriptions?
56.
 - a. Are your pharmacists required to submit usual and customary charges for each claim?
 - b. If yes, is the contracted price based on the lesser of discount or reasonable and customary?
 - c. How is this accomplished through the point-of-sale system?
 - d. How do you monitor compliance with usual and customary input?
57. When and under what circumstances are claims "pending"? Does a pending notice go into the system? Is there an automatic follow-up? What is the frequency of the follow-up? How many follow-ups are performed?

58. How do you avoid duplicate payments of the same claim? If duplicate payments or overpayments are made, what are your procedures for recovery of the overpayments or duplicate payments?
59. Give an approximate percentage of claims that are handled on-line using point-of-sale capability. What percentage are paper claims?
60. Explain your COB procedures and the average savings that you obtain and how COB savings are calculated. Do you pursue COB prospectively or retrospectively to payments? How do you know if there is other coverage? How often are records updated for new information on other coverage? How is COB handled by point-of-sale network pharmacies.
61. a. How do you coordinate claim payments with Workers= Compensation claims?
- b. Does your system allow you to deny claims for specific drugs for identified individuals?
- c. Explain your standard subrogation policy provisions and procedures and any options that are available, along with their advantages and disadvantages.
62. Explain how unusual claims and/or charges are handled. Do you retain pharmacist consultants for the review of any unusual claims or charges? If yes, explain the method in which such consultants are used and describe their qualifications. Also, indicate the savings in claim costs that are attributable to the use of these pharmacists and how that amount of savings is calculated. Does this outside organization or person have any other business or personal relationship with your organization or any member of your organization? If so, what is the relationship?
63. a. Describe the patient appeals policy and process.
- b. Include a description of the committee reviewing member grievances.

DRUG UTILIZATION REVIEW

64. Discuss the **concurrent** DUR program you are offering to the State, including:
- a. development and scope of program including implementation date of each component;
 - b. establishment of clinical criteria;
 - c. methods of intervention, tracking systems, report capabilities and feedback mechanisms;
 - d. descriptions and examples of each edit;
 - e. prevention of fraud and abuse;
 - f. measurement of program effectiveness;
 - g. integration with the Utilization Review program of the medical plan administrator;
 - h. calculation of savings.
65. Discuss your **retrospective** DUR program you are offering to the State, including:
- a. development and scope of program including implementation date of each component;
 - b. establishment of clinical and cost criteria;
 - c. methods of intervention, tracking systems, report capabilities and feedback mechanisms;
 - d. description of educational/informational materials;
 - e. ability to conduct focused DURs such as the prescribing of preferred products, controlled substances utilization, H-2 blockers, etc.;
 - f. measurement of program effectiveness;
 - g. integration with the Utilization Review program of the medical plan administrator;
 - h. calculation of savings.

66. Describe the **prospective** DUR program you are offering to the State, including:
- a. development and scope of program including implementation date of each component;
 - b. establishment of clinical and cost criteria;
 - c. methods of intervention, tracking systems, report capabilities and feedback mechanisms;
 - d. description of educational/informational materials;
 - e. measurement of program effectiveness;
 - f. integration with the Utilization Review program of the medical plan administrator
 - g. calculation of savings.
67. a. Does your DUR system provide real-time, point-of-dispensing, drug interaction warnings and other drug conflict alerts (e.g., age, pregnancy) to the retail pharmacies?
- b. What warnings and conflict alerts are your pharmacists allowed to override at the point-of-sale?
- c. What warnings and conflict alerts cannot be overridden by the pharmacist?
68. a. Describe your physician profiling program. What data elements are captured and tracked?
- b. What procedures do you have in place to correct any abusive, excessive or inappropriate prescribing patterns?
- c. What is your capability to intervene directly with physicians who do not meet your practice standards? Provide an example.
- d. Indicate the number of interventions that have been performed by your DUR program within the last 12 months? Within the last 24 months?
- e. Do you evaluate the appropriateness of the prescribing physician/practitioner credentials? How do you compare the prescribing physician=s/practitioner=s qualifications with the type of prescription written?

69. Do you monitor high cost claimants? What criteria are used to identify high cost claimants and what steps are taken to manage a claimant=s compliance with therapy?
70. Describe education provided to plan members, prescribing physicians and network pharmacies. Include sample material and indicate frequency.

INFORMATION SERVICES AND DATA REPORTING

71. The State requires a number of regular monthly, quarterly and annual claim reports. Indicate for each of the following reports whether or not you can provide such a report, and the frequency and timing of each report. Provide an example of each type of report as described in Attachment M.
72. Describe any other claim/management reports you would be able to supply to the State regularly at no additional charge and the frequency with which the reports could be provided.
73. a. Describe your computer system security measures.
b. Describe the system backup and disaster recovery procedures for your claims and network systems.
c. How often are the systems tested? When were the systems last tested and what were the results?
74. Provide a statement regarding your company's Y2K compliance status. Include specific descriptions of any system issues that could affect the State's benefits and payroll systems. Describe any system failures that occurred due to the year 2000 date change, including actions and time taken to correct the problems.
75. Is your network and/or mainframe processing support fully dedicated to your pharmacy network operations or do you share it with other organizations? If not fully dedicated, indicate the organizations that share the systems.

Network Structure and Services

76. Describe the retail pharmacy network structure you are offering to the State. Propose only one network. Include in your description any distinguishing features, including total number of pharmacies in the network. Are your provider contracts based on exclusive arrangements? Also indicate if this is an existing network or if the network is to be created for this RFP. Describe network leasing arrangements that impact any portion of the proposed network.
77. Complete the following table by checking those elements that are included in the pharmacy selection process and providing the percentage of pharmacies that satisfy the indicated selection criteria elements.

Criteria	Standard Selection Criterion (Check if Yes)	Percent of Pharmacies that Satisfy Criteria	Comments
Require Unrestricted Licensure			
Review Malpractice Coverage and History			
Require full disclosure of current litigation & other disciplinary activity			
Require Signed Application/Agreement			
Require Current DEA Registration			
On-site review of office location and appearance			
Review hours of operation and capacity			
On-site Electronic Access to Patient Data			
Review Practice Patterns			

Criteria	Standard Selection Criterion (Check if Yes)	Percent of Pharmacies that Satisfy Criteria	Comments
& Utilization Results			

78. a. Describe the general credentialing process and minimum criteria for selecting a network pharmacy. Include the minimum required malpractice coverage per individual practitioner or group. If the process differs by type of pharmacy (i.e, independent versus chain), indicate and describe separately.
- b. Provide sample copies of enrollment questionnaires and provider agreements/contract forms for the pharmacy network that will service the State's account.
- c. Provide the average number of years that a pharmacy contract is in effect.
79. For the service areas that will service the State, provide the number of participating

network pharmacies that were terminated in the past 36 months:

Terminations	Number of Pharmacies	Percentage of Pharmacies	Reasons
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By your company:

Voluntary
Withdrawal:

80. List the top five most common complaints by your network pharmacies concerning your operations and administration.

81.
 - a. Describe the organization, staffing and operation of your pharmacy relations department, including: size, hours of operation, personnel experience level and training.
 - b. Is there an oversight committee that addresses pharmacy relations issues?
 - c. If yes, what are the credentials of the staff members that serve on the committee?
 - d. What procedures are in place to monitor network grievances?
 - e. Describe the system for pharmacist phone inquiry and professional staff availability for responding to questions and problem situations.
 - f. Is there a toll-free service for pharmacists= inquiries?
 - g. How are after hour, holiday and emergency calls from pharmacists handled?

Coverage of Eligible Participants

82. Submit with each proposal a statement from each pharmacy in Maryland that will participate in the offeror's network. The statement must be signed by a person authorized to obligate the pharmacy to participate. If more than one pharmacy is owned by the same person or entity, a single statement may be submitted for all of the pharmacies so owned. Pharmacies may sign statements for more than one vendor. The form of the statement is attached as Attachment E. Each signed statement should have a unique statement number indicated on the upper right-hand corner in the space provided on Attachment E. Please refer to Section 5.2.3 for information regarding completion of Attachment E for the EPIC Pharmacy Network, Inc.

For questions #83-86, use only data for pharmacies for which you have a completed statement of participation - Attachment E. Your network will be evaluated based solely on the pharmacies that have completed the Pharmacy Participation Statement.

83. a. Provide the total number of participating pharmacies for the in-state pharmacy network, in each county and in Baltimore City. (Provide separately for chain pharmacies and independent pharmacies.)
- b. Indicate the percentage of pharmacies in each State of Maryland county and in Baltimore City that are participating pharmacies. (Provide separately for chain pharmacies and independent pharmacies.)
84. Indicate the total number of pharmacies in your out-of-state network, by state. Include the annual prescription drug volume and the electronic transmission capability for each state.
85. Indicate the methods and time frame for enlisting additional pharmacies.
86. Provide the following retail pharmacy data sufficient for a GeoAccess study. Data should be provided in ASCII format on a 3.5" diskette. Include a data layout description. For each pharmacy location provide:

Pharmacy Name

TIN

NABP ID

ZIPCode (5-digit)

Pharmacy Participation Statement number

Each pharmacy location should appear once in the data provided. Pharmacies without a signed pharmacy participation statement will not be considered.

QUALITY

DISEASE MANAGEMENT

87. a. Define any disease management programs included in your proposal.
- b. How does your disease management program differ from your retrospective DUR?
- c. Provide specific examples and specific illnesses/conditions that are managed.
- d. Describe your levels of expertise and resources dedicated to disease management outcomes.
- e. Describe how disease management outcomes are measured and how results are used.
- f. How will these programs impact the quality and cost of the State=s plan?

AUDITING

88. a. Describe in detail the claims auditing procedures established by your company (frequency, extent, etc.).
- b. Will you supply a copy of all such reports to the State?
- c. Describe how you ensure that the proper price is reimbursed to the pharmacy.
- d. What safeguards exist to prevent non-State claims from being charged to the State?
- e. What safeguards exist for preventing breaches in patient confidentiality with

regard to prescription claims information?

89. Pharmacy Audits

- a. Please describe your process for selecting and auditing pharmacies?
- b. Please state the percentage of all contracted pharmacies for which you perform bench audits? A bench audit is one where you examine the pharmacy electronically.
- c. Please state what factors found in a bench audit that will result in the next level of audit. Please describe the type of audit that would be conducted.
- d. Please state what triggers on an on-site audit.
- e. Please state the number of on-site audits conducted each year that are not random audits.
- f. Please state the number of random on-site audits conducted each year.
- g. Is the right to audit included in all your provider contracts?
- h. Please state the number of terminations that result from audit results and the most prevalent reason for termination.
- i. How will the State receive copies or summaries of the results of audits?
- j. How will recoveries be credited to the State?

QUALITY MANAGEMENT

- 90.
- a. List the key personnel or committee members who are responsible for setting clinical quality standards and overseeing any outcomes research or clinical studies. Include a brief summary of their credentials and past experience.
 - b. Summarize the quality assurance programs your company has in place to ensure that proper administration and dispensing are being provided.

Satisfaction Survey

- 91.
- a. Describe your proposed process for conducting the annual State member satisfaction survey. Describe your sample selection methodology so the State can be assured of a statistically valid result.
 - b. Does an outside organization perform the survey?
 - c. Provide a copy of the results of your most recent general member survey.

IMPLEMENTATION AND ACCOUNT MANAGEMENT

92. Provide a detailed implementation plan that clearly demonstrates the offeror's ability to meet the State's requirements to have a fully functioning program in place and operable on January 1, 2001. This implementation plan should include a list of specific implementation tasks/transition protocols and a timetable for initiation and completion of such tasks, beginning with the contract commencement and continuing through the effective date of operation (January 1, 2001). The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the State during implementation. The implementation plan should also specifically identify those individuals, by area of expertise, responsible for key implementation activities and clearly identify their roles. A detailed organizational chart as well as resumes should be included.
93. Provide a detailed management plan that clearly demonstrates the offeror's ability to manage this program on an ongoing basis.
 - a. The management plan should include the name, title and resume of the person with overall responsibility for planning, supervising, and performing account support services for the State. The management plan should also note what other duties, if any, this person has and the percentage of this person's time that will be devoted to the State.
 - b. The management plan should also include an organizational chart identifying the names, functions, and reporting relationships of key people directly responsible for account support services to the State. It should also document how many account executives and group services representatives will work full-time on the State's account, and how many will work part-time on the State's account.
 - c. The management plan should describe account management support, including the number of meetings to be held with the State annually (not less than quarterly), information to be reviewed at each meeting, frequency of ongoing communications, and assurance of accountability for account

services satisfaction. It should identify the location of all service centers that will be used to service this contract. It should also include the mechanisms and processes in place to allow Employee Benefits Division personnel to communicate with account service representatives; the hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available on-line. The Employee Benefits Division requires identification of an account services manager to respond to inquiries and problems, and a description of how the offeror's customer service and other support staff will respond to subscriber or client inquiries and problems. The management plan should include the names, resumes and a description of functions and responsibilities for all supervisors and managers that will provide services to the State with respect to this contract.

94. List any additional or optional services that you offer without additional charge that have not been requested.
95. Describe the benefits that will accrue to the Maryland economy as a direct or indirect result of your performance of this contract.
 - a. Indicate the amount or percentage (but not both) of contract dollars to be recycled into Maryland's economy in support of the contract through the use of Maryland subcontractors, Maryland suppliers, MBEs, and Maryland joint venture partners. Be as specific as possible. Provide a breakdown of expenditures in this category.
 - b. Indicate the number and type of jobs for Maryland residents resulting from this contract. Indicate job classifications, number of employees in each classification, and the aggregate payroll to which you commit at both prime and, if applicable, subcontract levels.
 - c. Estimate tax revenues to be generated for Maryland and its political subdivisions as a result of this contract. Indicate tax category (sales tax, payroll tax, inventory tax, and estimated personal income tax for new employees).
 - d. Indicate other benefits to the Maryland economy, which you promise will

result from the award of this contract. Please describe the benefit, its value to the Maryland economy, and how it will result from the contract award

SECTION 4. EVALUATION CRITERIA AND SELECTION PROCEDURE

4.1 EVALUATION CRITERIA

Evaluation of the proposals will be based on the criteria set forth below and developed from both the technical proposal and the financial proposal. In evaluating the proposals, technical merit will receive greater weight than price.

The following criteria listed in order of descending importance will be used to evaluate the quality, completeness and acceptability of offeror=s technical proposal.

1. Network
 - a. Network Structure and Services
 - b. Coverage of Eligible Participants
2. Organization
 - a. Experience
 - b. Past Performance on Similar Contracts
 - c. History and Structure
3. Administration
 - a. Program Administration
 - b. Customer Services
 - c. Claim Paying Services and Ability
 - d. Drug Utilization Review
 - e. Information services and data reporting
4. Quality
 - a. Disease Management
 - b. Auditing
 - c. Quality Management
 - d. Enrollee Satisfaction
5. Proposed Implementation and Account Management

6. Maryland Economic Impact

4.2 SELECTION PROCEDURE

The contract will be awarded in accordance with the competitive sealed proposals process under Code of Maryland Regulations 21.05.03. The competitive sealed proposals method is based on discussions and revision of proposals during these discussions.

Accordingly, the State may hold discussions with all offerors judged reasonably susceptible of being selected for award. However, the State also reserves the right to make an award without holding discussions. In either case of holding discussions or not doing so, the State may determine an offeror to be not responsible and/or not reasonably susceptible of being selected for award, at any time after the initial closing date for receipt of proposals. Financial proposals of qualified offerors will be opened only after all technical proposals have been evaluated.

After a review of the financial proposals of qualified offerors, the Procurement Officer may conduct discussions with the offerors.

Offerors must confirm in writing any substantive oral clarification of their proposals made in the course of discussions. When in the best interest of the State, the Procurement Officer may permit offerors who have submitted acceptable proposals to revise their initial proposals and submit in writing best and final offers.

Upon completion of all discussions and negotiations, reference checks, and site visits, if any, the Procurement Officer will recommend award of the contract to the responsible offeror whose proposal is determined to be the most advantageous to the State, considering price and the evaluation factors set forth in this RFP. In making the selection, technical merit will receive greater weight than price.

SECTION 5. PROPOSAL FORMAT

5.1 GENERAL

The proposal should address all points and questions outlined in the RFP. It should be clear and concise in response to the information and requirements described in the RFP. Do not include any promotional items or items not directly requested.

5.2 FORMAT OF THE PROPOSAL

Proposals must be submitted in two separate volumes, technical and financial. Technical volumes must be sealed separately from financial volumes but submitted simultaneously at the Issuing Office. An unbound original, so identified, and ten (10) bound copies of each volume are to be submitted.

Each offeror is required to submit a separate sealed package for each volume which is to be labeled ATechnical Proposal≡ (Volume I), AFinancial Proposal≡ (Volume II) and APharmacy Participation Statements≡ (Volume III). Each sealed package must bear the RFP title, name and address of the offeror, the volume numbers (I, II and III), and the closing date and time for receipt of the proposal on the outside of the package. A transmittal letter and a statement acknowledging receipt of any and all addenda should accompany the technical proposal. The sole purpose of this letter is to transmit the proposal; it should be brief and signed by an individual who is authorized to commit the offeror to the services and requirements as stated in the RFP. All proposals must be paged numbered from beginning to end.

5.2.1 Volume I - Technical Proposal

The Technical Proposal shall include:

a. Executive Summary

The offeror shall condense and highlight the contents of the Technical Proposal in a separate section titled AExecutive Summary.≡ The summary shall provide a broad

overview of the contents of the entire proposal and explain any deviations.

b. Offeror Qualifications

Provide a detailed discussion of the Offeror=s service capabilities and approaches to address the qualifications outlined in Section 2 of this RFP.

c. Completed Questionnaire

Repeat each number and question as provided in Section 3.5. Provide clear and complete responses. To assist offerors in the preparation of their responses, a disk copy of this questionnaire is available as part of the RFP in Wordperfect 6.1 or Microsoft Word 97 format. It is also available through the Department=s Internet web site address at: <http://www.dbm.state.md.us>, select Aprocurement≡.

d. Required Submissions

Offerors must submit:

1. Completed Proposal Affidavit (Attachment B - original copy only)
2. Certified Minority Business Enterprise (MBE) Utilization and Fair Solicitation Affidavit (See Section 1.19 and Attachment D-1).
3. Financial Statements and Annual Reports, (audited preferred).
4. Draft of Plan Description for Open Enrollment booklet (See question 33).
5. Signed Pharmacy Participation Statements (Attachment E) (See question 82).
- 6.** Network data in ASCII format (See question 86).

e. Subcontractors

Offerors must identify subcontractors and the role these subcontractors will have in the performance of the contract. Disclosure of MBE subcontractors at this point is optional.

5.2.2 Volume II - Financial Proposal

Under separate sealed cover from the Technical Proposal and Pharmacy Participation Statements and clearly identified with the same information noted on the Technical Proposal, the Contractor must submit an unbound original and ten (10) copies of the Financial Proposal. The Financial Proposal must contain all cost information in the format specified in Attachment K of this RFP.

5.2.3 Volume III - Pharmacy Participation Statements

Under separate sealed cover from the Technical and Financial Proposals, the Contractor must submit an unbound original and ten (10) copies of the Pharmacy Participation Statement (s). The Pharmacy Participation Statement must contain a completed Attachment E for each pharmacy in the Contractor=s network.

Attachment E may be completed by EPIC Pharmacy Network, Inc. (EPIC) on behalf of each EPIC pharmacy for which EPIC has an existing participation agreement and has received, on or before, the due date of the proposals, a written acknowledgement that the pharmacy will participate in the network resulting from the RFP. Pharmacies that are included in the EPIC network may also execute independently Attachment E and provide it to the same or different PBM. There is no limit on the number of Attachment E forms that may be executed by a pharmacy.

ATTACHMENTS

In accordance with State Procurement Regulations, the Proposal Affidavit, **Attachment B** and Certified MBE Utilization and Fair Solicitation Affidavit, **Attachment D-1** , must be completed and submitted with the Technical Proposal, and the Contract Affidavit, **Attachment C**, must be submitted at the time of contract award notification.